Welcome To Tufts Health Plan.

You will receive your **ID card and Evidence of Coverage** shortly. In the meantime, as a new member, it is ESSENTIAL for you to - -

- Choose your Primary Care Physician immediately. Tufts Health Plan will cover ONLY those medical services authorized by your Primary Care Physician (except in an emergency). If you need help choosing a Primary Care Physician, please call a Customer Relations Coordinator at 800-462-0224.

- Go to the nearest medical facility in an emergency. An emergency is a serious injury or the onset of a serious condition, that prevents you from taking the time to call your Primary Care Physician.

- Contact your new Primary Care Physician immediately. Introduce yourself as a new member and find out whether your physician would like to schedule a physical exam. TRANSFER your medical records to your new Primary Care Physician immediately.

- Contact your Tufts Health Plan Primary Care Physician first when you are sick, instead of calling any other doctor.

- CALL US with any questions—our CUSTOMER RELATIONS COORDINATORS are here to help you learn how to use the PLAN. We're at 800-462-0224.

Commonwealth of Massachusetts

TUFTS Health Plan

Subscriber's Medicare #_____

You must have Medicare Parts A and B to enroll.

Please complete this form in full.

TUFTS MEDICARE COMPLEMENT MEMBERSHIP APPLICATION

EMPLOYER OR TUFTS HEALTH PLAN USE ONLY
GROUP NAME:_____
GROUP #_____
EFF. DATE:____/____/____
REASON CODE:_____

LAST NAME	**FIRST NAME**	**MI**	☐ **MALE** ☐ **FEMALE**	**DATE OF BIRTH** _____/_____/_____ MONTH DAY YEAR

MAILING ADDRESS	**HOME ADDRESS** (IF DIFFERENT)	**CITY**	**STATE**	**ZIP**	**TELEPHONE** ( )

YOUR PRIMARY LANGUAGE	**PRIMARY CARE PHYSICIAN** (FIRST AND LAST NAME)	**DO YOU CURRENTLY USE THIS PHYSICIAN?** ☐ **YES** ☐ **NO**

PRIMARY CARE PHYSICIAN ID#	**TUFTS HEALTH PLAN AFFILIATED HOSPITAL**	**CHOICE OF FITNESS CENTER AND CITY/STATE**

IMPORTANT - TO ENROLL, PLEASE ATTACH A COPY OF YOUR MEDICARE CARD.

- Do you currently have Tufts Health Plan through a group plan? ☐ **YES** ☐ **NO** If yes, what is your membership number? _____
- Are you or your spouse **actively working** for the sponsoring employer? **(you)** ☐ **YES** ☐ **NO** **(spouse)** ☐ **YES** ☐ **NO**
- Has endstage renal disease qualified you for Medicare parts A & B? ☐ **YES** ☐ **NO**

If yes, please indicate your certification dates: Part A _____/_____/_____
Part B _____/_____/_____

PLEASE READ THE PARAGRAPH BELOW, SIGN AND RETURN THIS APPLICATION TO YOUR EMPLOYER

The information supplied on this form is true and complete. I acknowledge that I must continue to be enrolled in Medicare Parts A & B or I will be ineligible for Tufts Medicare Complement coverage effective as of the date I discontinue either Medicare Part A or B. I authorize my employer (sponsor) to remit my share of Tufts Medicare Complement (TMC) premium together with any contributions by my employer (sponsor). I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me. I grant Tufts Health Plan any legal right that I may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid for by Tufts Health Plan. I agree that Tufts Health Plan and health care providers may obtain or release my medical records and medical services-related information for the following purposes: (a) administering benefits; (b) managing care, including utilization review, quality assurance and member satisfaction procedures; (c) conducting bona fide medical research; and (d) when required by law. I understand that, except in an emergency, all health services must be provided or authorized by the Tufts Health Plan Primary Care Physician that I have designated. I understand that calls to the Customer Relations Department may be monitored for quality assurance. I understand that the benefits for which I will be eligible are those described in the Tufts Medicare Complement (TMC) Evidence of Coverage.

SIGNATURE:_____ **DATE:**_____

BENEFITS DEPARTMENT SIGNATURE:_____ **DATE:**_____

TUFTS Health Plan

TUFTS MEDICARE COMPLEMENT

Welcome to the Tufts Medicare Complement (TMC) plan.
Please read the information below before completing the membership application.

Please complete the membership application **in full or your application cannot be processed.** If you need assistance or have any questions while completing this application, please call a Tufts Health Plan Customer Relations Coordinator at 800-462-0224.

1.) Please complete the membership application in full. We cannot process your application until we have received all necessary information.
- A separate TMC application must be completed for each additional dependent enrolling in Tufts Health Plan.
- If your dependent(s) are not Medicare eligible, they must complete a regular Tufts Health Plan membership application.

2.) Enclose a copy of your Medicare Claim Card and one of the following Social Security forms: SSA-2458, Third Party Query, HCFA 1585, SSA 1099 SM, SSA L30, or SSA 4926.
- These Social Security forms may be obtained from your local Social Security office.

3.) Return the following to the State Enrollment Coordinator at the Tufts Health Plan:
1.) A Tufts Medicare Complement (TMC) Membership Application
2.) Copy of Medicare Claim Card
3.) One Social Security Form

I agree to and understand that if I (a) obtain a health benefit or payment from Tufts Health Plan that I know I am not entitled to receive or be paid; or (b) knowingly present or cause to be presented, with fraudulent intent, a claim that contains a false statement, I can be liable to Tufts Health Plan for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

Tufts Health Plan arranges for the provision of health care services, but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents or representatives of Tufts Health Plan for any purposes.

We speak 140 languages.
Call for translation services:

800-462-0224

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
យើង និយាយ ភាសាខ្មែរ
Νιμανε Εμμθξιλα

TDD 800-815-8580

Tufts Health Plan
705 Mt. Auburn Street
P.O. Box 9164
Watertown, Massachusetts 02471-9164
800-462-0224

In Massachusetts: Tufts Associated Health Maintenance Organization, Inc.